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U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

1999 Medical Expenditure Panel Survey

Insurance Component

HEALTH INSURANCE COST STUDY

PLAN INFORMATION QUESTIONNAIRE

Please correct errors in name, address, and ZIP Code.
ENTER number and street if not shown.

PLAN INFORMATION

FOR CENSUS USE ONLY

100

ENTER THE FIVE DIGIT PLANT NUMBER OF THE ORIGINAL CASE.

For your *(Fill in establishment address from above)* location, please answer these questions for the health plan with the *(largest/next largest)* enrollment.

1a. For 1999, what was the name of the health insurance plan with the *(largest/next largest)* enrollment of active employees?

012

_____
Name of plan

1b. Is this the same plan as described for a previous location?

☐ Yes
☐ No – ***GO TO 2***

1c. Are plan premiums and other characteristics about this plan consistent between this location and the one we previously discussed?

☐ Yes – ENTER PLANT NUMBER ABOVE AND ***SKIP TO 12a ON PAGE 4***
☐ No

The following questions are about the *(fill in plan name from above).*

2. Was this plan **purchased** from an insurance underwriter or was it **self-insured** by your organization?

105 1 ☐ Purchased from an insurance underwriter (fully insured) – ***SKIP to 5 ON PAGE 2.***
2 ☐ Self insured

PLAN INFORMATION – Continued

3. Was this plan self-administered or did your organization employ an insurance company or other administrator?

106
1 ☐ Self-administered
2 ☐ Insurance company or other administrator

4. Did your organization purchase stop-loss coverage?

107
1 ☐ Yes
2 ☐ No
} ***SKIP TO 6***

5. What was the name of the insurance company or carrier providing this plan?

102 _____

Name of insurance carrier

6. Which type of health care provider was available through *(fill plan name)*? Were the providers –

<READ EACH CATEGORY AND MARK (X) ONLY ONE>

DO NOT READ TERMS IN PARENTHESES

103
1 ☐ Exclusive providers the **enrollee must use** in non-emergency situations, (HMO,IPA, EPO)
2 ☐ Any providers the **enrollee chooses** on a fee-for-service basis, or (CONVENTIONAL, IDEMNITY)
3 ☐ A mixture of preferred providers and any providers, where the enrollee pays one fee when using a provider associated with the plan and a **slightly higher fee** if he or she goes to a provider **outside the preferred group?** (PPO, POS)

7. Did this plan **require** that the enrollee see a primary-care physician in order to be referred to a specialist?

104
1 ☐ Yes
2 ☐ No

PLAN INFORMATION – Continued

8a. Was single coverage offered under this plan?

552 1 ☐ Yes

2 ☐ No – ***SKIP to 9a***

8b. For this plan, how much did **one typical** full-time employee with **single coverage** contribute toward his or her own premium?

132 $ _____.00 Employee contribution – Single

<MARK (X) ONLY ONE>

☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Quarterly ☐ Yearly

8c. What was the *(If self-insured 'monthly premium equivalent', else, 'total premium')* for this employee with single coverage, including both the employer and employee contributions?

130 $ _____.00 **Total premium – Single**

8d. <ASK OR VERIFY> On which of the following time periods are these amounts reported: weekly, every 2 weeks, monthly, quarterly, or yearly?

<MARK (X) ONLY ONE>

133 ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Quarterly ☐ Yearly

9a. Was family coverage offered under this plan?

137 1 ☐ Yes

2 ☐ No – ***SKIP TO 10 ON PAGE 4***

9b. For the plan just mentioned, how much did **one typical** full-time employee with **family coverage** contribute toward his or her own premium?

READ IF NECESSARY: **Report for a typical family of four if cost varies by family size.**

136 $ _____.00 Employee contribution – Family

<MARK (X) ONLY ONE>

☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Quarterly ☐ Yearly

9c. What was the *(If self-insured, 'monthly premium equivalent', else, 'total premium')* for this employee with family coverage, including both the employer and employee contributions?

134 $ _____.00 **Total premium – Family**

9d. <ASK OR VERIFY> On which of the following time periods are these amounts reported: weekly, every 2 weeks, monthly, quarterly, or yearly?

<MARK (X) ONLY ONE>

553 ☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Quarterly ☐ Yearly

PLAN INFORMATION – Continued

10. Did this plan have a deductible?

151 1 ☐ Yes
2 ☐ No

11. Which of the following services were covered under this plan for the 1999 plan year:
<READ EACH CATEGORY>

		Yes (1)	No (2)	Don't know (3)
165	Adult routine physical exams	☐	☐	☐
166	Routine pap smears	☐	☐	☐
170	Well baby care, under 1 year	☐	☐	☐
176	Routine dental care	☐	☐	☐
180	Inpatient mental illness	☐	☐	☐

12a. How many of the active employees you reported earlier for this location were enrolled in this plan, during a typical pay period in 1999?

125

_____ Active employees enrolled

12b. What percentage of these enrolled employees had **single coverage**?

542

_____ % of active employees enrolled in single coverage

OR

129

_____ Number of active employees enrolled in single coverage

END

<DO NOT READ ALOUD>

- IF THERE IS A SECOND (OR THIRD) PLAN FOR THIS ESTABLISHMENT – GO TO ANOTHER MEPS-10M(S) QUESTIONNAIRE FOR THAT PLAN.
- IF YOU HAVE ALREADY COLLECTED INFORMATION FOR THREE PLANS FOR THIS ESTABLISHMENT – GO TO THE MEPS-10M QUESTIONNAIRE FOR THE NEXT ESTABLISHMENT.
- IF THERE ARE NO MORE PLANS FOR THIS ESTABLISHMENT – GO TO THE MEPS-10M QUESTIONNAIRE FOR THE NEXT ESTABLISHMENT.
- IF THERE ARE NO MORE ESTABLISHMENTS – END THE INTERVIEW BY READING THE THANK YOU STATEMENT.

THANK YOU

This concludes the Health Insurance Cost Study. Thank you very much for your time and cooperation.